LOUISIANA PATIENT'S COMPENSATION FUND

NURSING AND ASSISTED LIVING FACILITY APPLICATION

(for those with underlying self-insurance)

NAME AND PHYSICAL ADDRESS OF INSTITUTION **LICENSE #:**_____

_____

_____

_____

DATES OF ENROLLMENT APPLYING FOR:_____

AMOUNT OF SURCHARGE BEING REMITTED:_____

1. **NAME OF MANAGEMENT COMPANY:**_____
(Please note that a separate application is required if coverage is being requested)

2. **NAME OF CORPORATE OWNER:**_____
(Please note that a separate application is required if coverage is being requested)

3. **PROFESSIONAL LIABILITY EXPOSURES** (furnish daily census data):

Number of beds maintained: (Beds mean total number of beds used for patients)		**Average number occupied**: (Average number occupied is the sum of the daily number of beds used for patients during the preceding 12 months, divided by 365.)	
Skilled		Skilled	
Intermediate		Intermediate	
Assisted Living		Assisted Living	

Number of outpatient visits: _____
(Including home health visits and hyperbaric treatments.)

4. **PROFESSIONAL EMPLOYEES:**

a. Indicate total number of employees in each class:

	Register Nurses		LPN/LVNs
	Pharmacists-**(see rate manual)**		Heart-Lung Technicians
	X-Ray Technicians		Paramedics/EMTs
	Lab Technicians		Student Nurses
	Other		

b. Are above employees to be included as additional insureds? _____

c. **Employed physicians (including Medical Directors), surgeons, Nurse Practitioners, nurse Physician Assistants and Pharmacists must submit an individual application along with the appropriate surcharge.**

5. **PREVIOUS EXPERIENCE:**

a. Name of previous liability carrier: _____

b. List all claims or suits filed in the last ten years. Attach a separate list if necessary

DATE	DESCRIPTION	OPEN / CLOSED	TOTAL INCURRED

Your attention is directed to LAC 37:III, Chapter 11, §§1101-1105, which sets froth the cost and reserve reporting requirements which you must satisfy within the time allotted therein. Please note §1105 which provides for the cancellation of and termination of enrollment with the Patients' Compensation Fund for failure to comply with these reporting requirements.

I further certify that the appropriate security (proof of financial responsibility) is in place and current at _____institution.

INCLUSIONS:

Employed allied healthcare providers. This does not include those who require a PCF surcharge, such as, MD's, NP's, PA's, CNS', CRNA's, etc.

PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:

(1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.

(2) Third (3rd) party claims filed by an injured party that was not a patient of the health care provider.

(3) Services or treatment rendered as a licensed provider in states other than Louisiana.

SIGNATURE OF ADMINISTRATOR: _____

DATE: _____

CONTACT PERSON AND PHONE #:_____

EMAIL ADDRESS:_____